

Wayne S. Amaral  
Traffic Operations Manager  
(617) 349-4723

**Applicant's Name:**      **First** \_\_\_\_\_ **Last** \_\_\_\_\_

**Applicant's Street Address:** \_\_\_\_\_ **Cambridge, MA**    **ZipCode:** \_\_\_\_\_

**Phone Numbers:** \_\_\_\_\_  
(e.g. (617) 555-0000)

**Vehicle Registration Number:** \_\_\_\_\_ **Placard Number:** \_\_\_\_\_

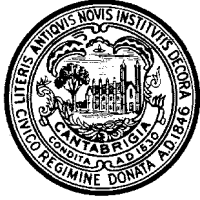
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\_\_\_\_\_ (Use the back if you need more space.)

I have read the City of Cambridge policy for establishing handicap parking spaces on public streets in residential areas, and I understand the conditions required for a designated handicap parking space. I also understand that if I fail to meet the eligibility requirements, I will have the opportunity to appeal for a waiver.

I certify that the information provided is correct. I also give permission for the Cambridge Commission for Persons with Disabilities or Cambridge Traffic, Parking and Transportation to obtain all information necessary to verify my need for this designated parking space.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_



**CITY OF CAMBRIDGE**  
**Traffic, Parking and Transportation**  
344 Broadway  
Cambridge, Massachusetts 02139

Susan E. Clippinger  
Director  
(617) 349-4700

Wayne S. Amaral  
Traffic Operations Manager  
(617) 349-4723

**City of Cambridge Traffic, Parking and Transportation Department**  
**Request for Residential Handicap Parking Space**

Applicant's Name: First

Last

Applicant's Street Address:

Cambridge, MA

**TO BE COMPLETED BY ATTENDING PHYSICIAN or OTHER HEALTHCARE PROFESSIONAL**

**To Physician:** Approval for a Residential Handicap Parking Space is based in part on information provided by you. If this applicant (your patient) has a "hidden" disability (i.e.: one that is not visibly obvious), it will be incumbent on you to specify the extent to which the disability limits the person's mobility in order for our Review Committee to make a fair evaluation of this application. Residential Handicap Parking Spaces are available only to those with substantial functional limitations that affect mobility for more than **six months**.

**Please answer the following:**

Does the applicant have mobility impairment?

☐ No

☐ Yes

Note which, if any, of the following impairments is attributable to the applicant and explain:

☐ Loss of use of one or more limbs

☐ Vision impairment

☐ Knee, ankle, hip dysfunction

☐ Respiratory, heart or circulatory disorder

Are mobility aids prescribed?

☐ No

☐ Yes; please specify:

☐ cane

☐ crutches

☐ walker

☐ wheelchair

Ambulatory range of the applicant:

Without rest

With intermittent rest

\_\_\_\_\_ distance in feet

\_\_\_\_\_ distance in feet

Describe any other functional limitations that make having a Residential Handicap Parking Space desirable:

\_\_\_\_\_  
\_\_\_\_\_

Physicians name (please print): \_\_\_\_\_ Phone: \_\_\_\_\_

Medical specialty: \_\_\_\_\_ Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_

**I hereby certify that the above information is correct.**

Date \_\_\_\_\_ Physician's signature \_\_\_\_\_

**PLEASE MAIL TO:**

Cambridge Traffic, Parking and Transportation Department  
ATTN: Wayne S. Amaral  
344 Broadway  
Cambridge, MA 02139